TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Brian D Shepler

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-15-2654-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "ESIS paid the amount of $125.00 to the balance of this claim. A total of $160.80 is due."

Amount in Dispute: $198.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $125.00."

Response Submitted by: ESIS Bill Review, 1851 E 1st St #200, Santa Ana, CA 92705

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2014	99214, 15851, 99080	$198.70	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 8 – National Correct Coding Initiative edit = either mutually exclusive of or integral to another service performed on the same day.
   - 1 – The appropriate modifier was not utilized

- 236 – This procedure or procedure/modifier combination is not compensable with another procedure on the same day according to the NCCI edit or work comp state regs/fee schedule requirements

Issues

1. Is that carrier's denial supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the disputed services as 236 – "This procedure or procedure/modifier combination is not compensable with another procedure on the same day according to the NCCI edit or work comp state regs/fee schedule requirements." Review of the disputed services finds;
   - Per Medicare policy, procedure code 99214, service date May 1, 2014, may not be reported with procedure code 15851 billed on this same claim with supporting documentation to indicate a separate and distinct service was performed. No modifier was used. No additional payment can be recommended.
   - Procedure code 15851, service date May 1, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.86 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.86. The practice expense (PE) RVU of 1.81 multiplied by the PE GPCI of 0.916 is 1.65796. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.816 is 0.08976. The sum of 2.60772 is multiplied by the Division conversion factor of $55.75 for a MAR of $145.38. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $110.00.
   - Procedure code A4550, service date May 1, 2014, has a status indicator of B, which denotes a bundled code. Payments for these services are always bundled into payment for other services to which they are incident.
   - Procedure code 99080 is specific to Texas Department of Workers' Compensation. The total amount allowed is $15.00

The total allowable reimbursement for the services in dispute is $125.00. This amount less the amount previously paid by the insurance carrier of $125.00 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.